



Ipswich and East Suffolk  
Clinical Commissioning Group

**IPSWICH AND EAST SUFFOLK CCG  
PRIMARY CARE COMMISSIONING COMMITTEE**

**Tuesday, 26 November 2019 at 2.00pm  
Two Rivers, 30 Woodbridge Road East, Ipswich, Suffolk, IP4 5PB**

**AGENDA**

- |      |   |   |
|------|---|---|
| 1400 | <b>1. Apologies for Absence</b>   | <i>Chair</i>                                |
| 1402 | <b>2. Declarations of Interest</b>  | <i>All</i>                                  |
| 1407 | <b>3. Minutes of Previous Meeting</b><br><i>To approve minutes of Ipswich and East Suffolk CCG Primary Care Commissioning Committee meeting held on 22 October 2019</i>                                 | <i>Chair</i>                                |
| 1409 | <b>4. Matters arising and review of outstanding actions.</b><br><i>To review outstanding issues from the previous meeting of the Ipswich and East Suffolk CCG Primary Care Commissioning Committee.</i> | <i>Chair</i>                                |
| 1415 | <b>5. General Update</b><br><i>To receive a verbal report from the Chief Operating Officer, Ipswich and East Suffolk CCG</i>  | <i>Maddie Baker-Woods</i>                   |
| 1420 | <b>6. Primary Care Estates- Investment and Revenue Implications</b><br><i>To receive and approve a report from the Director of Corporate Services and System Infrastructure</i>                         | <i>Amanda Lyes<br/>(IESCCG PCCC 19-30)</i>  |
| 1430 | <b>7. Primary Care Contracts and Performance</b><br><i>To receive and note a report from the Primary Care Commissioning Manager</i>   | <i>David Brown<br/>(IESCCG PCCC 19-31)</i>  |
| 1440 | <b>8. Primary Care Networks – Development Funds</b><br><i>To receive and note a report from the Primary Care Commissioning Manager</i>  | <i>David Brown<br/>(IESCCG PCCC 19-32)</i>  |
| 1450 | <b>9. Primary Care Delegated Commissioning – Finance Report</b><br><i>To receive and note a report from the Director of Finance, Ipswich and East Suffolk CCG</i>                                       | <i>Jane Payling<br/>(IESCCG PCCC 19-33)</i> |
| 1500 | <b>10. Annual Plan of Work</b><br><i>To receive, note and update the Committee's Annual Plan of Work</i>  |   |
| 1510 | <b>11. Date and Time of next meeting</b><br><i>2.00pm – 4.00pm, Tuesday, 25 February 2020, Britten Room, Endeavour House, 8 Russell Road, Ipswich, Suffolk.</i>   |   |



1515 **12. Questions from the public – 10 minutes**

This is a meeting in public and not a public meeting. Members of the public are invited to attend as observers. Questions on the commissioning of primary care are welcome. It is helpful if these are received at least three working days in advance\* so that as full an answer as possible may be given at the meeting. Questions may still be asked without prior submission and if it is not possible to provide an answer at the meeting then a written response will be supplied within seven days and also circulated to members of the committee.

In relation to the business to be covered, it is possible for members of the public to ask a question or raise an issue on a specific matter, subject to time available. Questions will be taken at the chair's discretion at a suitable point in the discussion but after the paper has been presented.

Questions prior to the meeting can be submitted to;

Jo Mael, Corporate Governance Officer – [jo.mael@suffolk.nhs.uk](mailto:jo.mael@suffolk.nhs.uk)  
Ipswich and East Suffolk CCG  
Endeavour House  
8 Russell Road  
Ipswich  
Suffolk  
IP1 1BX



**Meeting of the Ipswich and East Suffolk CCG Primary Care Commissioning Committee  
held on Tuesday 22 October 2019, in public, at  
The Mix, 127 Ipswich Street, Stowmarket, Suffolk**

**(This meeting was held with the Primary Care Commissioning Committee of West Suffolk  
CCG in line with 'in common' meeting arrangements)**

**PRESENT:**

Irene Macdonald	Lay Member: Patient and Public Involvement (Chair)
Maddie Baker-Woods	Chief Operating Officer
Steve Chicken	Lay Member
Dr Lorna Kerr	Secondary Care Doctor
Jane Payling	Director of Finance

Annette Agetue-Smith	NHS England Representative
Wendy Cooper	NHS England Representative
Simon Jones	Local Medical Committee
Dr Mark Shenton	CCG Chair

**IN ATTENDANCE:**

David Brown	Deputy Chief Operating Officer
Jo Mael	Corporate Governance Officer
Lynda Tuck	Lay Member: Patient and Public Involvement, West Suffolk CCG
Kate Vaughton	Director of Integration, West Suffolk CCG
Lois Wreathall	Head of Primary Care, West Suffolk CCG

**19/56 APOLOGIES FOR ABSENCE**

Apologies for absence were noted from;

Dr Christopher Browning, West Suffolk CCG Chair  
Ed Garratt, Chief Officer  
Amanda Lyes, Director of Corporate Services and System Infrastructure  
Stuart Quinton, Suffolk Primary Care Contracts Manager, NHS England  
Cllr James Reeder, Health and Wellbeing Board  
Andy Yacoub, Healthwatch

**19/57 DECLARATIONS OF INTEREST**

Dr Mark Shenton declared an interest in the agenda as holder of a Personal Medical Services (PMS) contract.

Kate Vaughton declared an interest in the agenda insofar as it related to West Suffolk NHS Foundation Trust, as a non-voting Board member of the Trust.

**19/58 MINUTES OF THE PREVIOUS MEETING**

The minutes of an Ipswich and East Suffolk CCG Primary Care Commissioning Committee meeting held on 23 July 2019 were **approved** as a correct record.

#### **19/59 MATTERS ARISING AND REVIEW OF OUTSTANDING ACTIONS**

There were no matters arising and the action log was reviewed and updated.

19/50 – Finance – Clinical Indemnity Scheme – the Director of Finance reported that there was no firm decision with regard to future funding at present and therefore current arrangements would continue. The action could be closed.

#### **19/60 GENERAL UPDATE**

The Chief Operating Officer reported:

- There had been positive engagement of Primary Care Network Clinical Directors, GPs and primary care nurses in relation to the CCG's Clinical Leadership Programme. 300 had attended a recent training and education event.
- Recent prescribing figures for August 2019 indicated an £245k overspend which was due to increased costs associated to CATE M and No Cheaper Stock Obtainable (NCSO) medications.
- Clinical Directors of Primary Care Networks were due to meet with core leadership teams next week to consider development of a joint needs assessment.

**The Committee noted** the update.

#### **19/61 PRIMARY CARE NETWORKS (PCNs) – AN UPDATE**

The Committee was reminded that it had previously approved the proposed configuration of PCNs in Suffolk and all PCNs had been implemented from 1 July 2019. The Committee was now in receipt of a report which set out progress in respect of the PCNs' ongoing development. Key points highlighted included:

Each PCN was considering its position and response to the offer of two reimbursed roles, that of a social prescriber (100%) and a clinical pharmacist (70% contributed by the CCG).

The PCNs all had the use of a maturity matrix diagnostic tool to assess where they thought they were and to help facilitate progress towards maturity in their systems and localities. A development support prospectus had also been circulated (Appendix 3) for them to consider where their PCN funding would be best directed.

Appendix 4 to the report detailed funding available for Suffolk PCNs, and it was noted that GP retention, reception and clerical training funding was being managed through the Training Hub Advisory Group. The online consultation monies had been spent via the IT team with every non Suffolk Primary Care (SPC) practice in Suffolk being offered E-consult.

PCNs were planning to fulfil their extended hour obligations individually and so had not begun to share patient care and data across their PCN.

The One Clinical Community Programme, which Clinical Directors were participating in, had begun in West Suffolk on 1 October 2019. The programme had been designed to provide clinicians and senior managers with protected time to work together on key priorities within localities. Ipswich and East Suffolk Clinical Directors had participated in two One Clinical Community programmes held last year or the GP Development Programmes which had taken place in previous years.

There are plans to implement a Population Health Management system across the integrated care system

The CCG was working with the Local Pharmaceutical Committee to ensure local pharmacies were able to deliver on the PCN element of their new contract.

Next steps included:

Primary Care Networks would continue to develop incrementally over the next five years with key areas of work being:

To receive and manage the funding for enhanced access (GP+ service)

To deliver seven network specifications (introduced over the next few years) that included:

- Medicines reviews and optimisation
- Advanced health in care homes
- Anticipatory care for high need patients
- Personalised care (Personal Health Budgets)
- Supporting early cancer diagnosis
- CVD prevention and diagnosis
- Tackling neighbourhood inequalities

Points highlighted during discussion included:

- The Committee was informed that three different population health management systems were to be introduced into three PCNs.
- Clinical Directors of PCNs were paid by the CCG and contracted for one day a week. The Clinical Directors were appointed by their own network and did not have to be GPs.
- Any impact on integrated neighbourhood teams or localities was, as yet, unknown and **it was agreed** that further information be provided for the next update. There was a request, that in order to minimise confusion in respect of the terms of 'integrated neighbourhood teams' and 'localities' that there be consistency in respect of terminology across the CCGs.

**The Committee noted** the content of the report.

## 19/62 PRIMARY CARE DELEGATED COMMISSIONING – FINANCE REPORT

The Committee was provided with an overview of the Primary Care Delegated Commissioning Budget at month six.

At the end of month six, the GP Delegated Budget spend was £537k over spent. Key variances were detailed in paragraph 2.1 of the report. Other Primary Care showed an under spend of £843k at the end of month six.

Other risks not reflected in the above full year forecasts were further increases in rent reimbursement, additional practice management support and an increasing number of claims for locum allowance for parental and sickness absence.

In light of the current situation there was concern expressed going forward, particularly as the GP+ budget was due to transfer to Primary Care Networks. The need to monitor the situation closely and plan for the next two years was highlighted.

**The Committee noted** the financial performance at month six.

## 19/63 WORKFORCE UPDATE

The Committee was provided with an update on the work of the Primary Care Development Team in delivering the Suffolk and North East Essex workforce plan and the Suffolk and North East Essex Training Hub and their impact on local workforce.

The NHS Long Term Plan, the GP Contract and the development of Primary Care Networks were all having an impact on General Practice Workforce. NHS England and Health Education England were channelling resources into the Integrated Care System (ICS) and CCGs to develop the workforce to deliver those strategies.

Whilst General Practice had a major challenge created by having an ageing workforce, there were exciting new opportunities created by establishing multi-disciplinary teams in General Practice who are providing more appropriate, specialised patient care.

The development of collaborative working provided by Primary Care Networks was offering career development opportunities through training and upskilling programmes.

The report went on to detail work in respect of the acquisition of workforce data, key messages identified from the data, apprenticeships and initiatives underway or planned across the workforce.

Workforce remained the largest challenge facing the whole health and social care sector of which General Practice was one employer. The sector needed to recruit new staff to ensure there were sufficient staff with the right skills to deliver patient services along the whole pathway, together with upskilling existing staff to be able to take on new roles and deliver new services.

The Training Hub was working collaboratively with other employers through a career project 'Next Generation' to attract young people to join the sector. The Training Hub was also working through the West Suffolk Training Hub Advisory Group to better understand the specific local challenges within General Practice.

During discussion it was clarified for the Committee that the report was incorrect in stating that 'summer GP data historically shows a decrease due to GP Trainees who have completed no longer showing in the data'.

The Local Workforce Action Group (LWAG) was working across the Alliance to seek to better understand workforce gaps at a local level.

It was queried whether the CCG was measuring how many locally trained staff remained in the area, and concern was expressed at the declining numbers of training practices which it was felt would have a 'knock on' effect in attracting future staff.

Having suggested that work be carried out to increase communication and promote the local area, which should include the promotion of training resources, **it was agreed** that the issue be fed back to the Alliance.

**The Committee noted** the content of the report.

## 19/64 PRIMARY CARE PERFORMANCE – UNWARRANTED VARIATION

The Committee was in receipt of a report which sought review of the identified variation and comments and suggestions for action as appropriate.

The CCGs primary care teams regularly analysed and reported on performance data and

metrics to the Primary Care Commissioning Committee. The approach was generally a holistic one, aimed at understanding why a particular practice was performing better or worse in comparison to another, with an ultimate aim of supporting practices to achieve a certain standard; thus ensuring high quality across all practices in Suffolk.

The current general approach to variation was to engage with any practice below the average or national target and to offer targeted support and challenge as appropriate to the objective. Such variations were raised with practices individually via Link visits, more broadly in Chart of the Week or as part of a two-way dialogue with the practice.

The approach to performance management was always incremental and proportionate.

The CCGs had recently undergone an exercise to attempt to gain a greater understanding as to what level variation in performance was recognised and accepted or was perhaps unwarranted.

The CCGs primary care teams had analysed a cross section of performance data with a view to understanding patterns, trends, variation and where possible, provide a quantifiable rationale for identified variance. To understand what was 'unwarranted' or variation that was deemed outside the normal range, a recognised formula of standard variation had been applied to each set of metrics to provide key focus. i.e. the best and worst performing practice in each category.

The primary care teams had collectively analysed the results to provide a narrative, a logic and a reasoned explanation to help understand the findings. The standard variation formula had been applied to a broad range of information held by the CCGs in relation to Local Enhanced Service performance and national targets.

Next steps included:

- To develop practice level trend data and relative context to be used at Link visits and for internal scrutiny and assurance
- To provide statistical process control data and importantly an 'explanation over time'
- To consider the data measured by the CCG to include new indicators associated with the Primary Care Network (PCN) Direct Enhanced Service (DES). i.e. Stage one cancer diagnosis

The Committee felt that there needed to be distinction between processes and behaviours and advised of the need to consider work already being carried out across the localities to ensure there was no duplication.

**The Committee noted** the content of the report.

## **19/65 INTEGRATED CARE SYSTEM (ICS) – 5 YEAR STRATEGIC PLAN UPDATE**

The Committee was in receipt of a report which provided an opportunity to review the draft content of the Integrated Care System (ICS) five year Strategic Plan; primary medical care sections.

On 28 September 2019, the ICS Programme Director had submitted to NHS England and NHS Improvement the Draft Five Year System Strategic Plan for Suffolk and North East Essex ICS prior to its finalisation in November 2019.

The two main sections that related to primary care were a one-page summary of the recently drafted primary care strategy and an overview of Primary Care Networks (PCNs).

There were a number of opportunities for the plan to be reviewed, discussed and further developed by the ICS Chairs Group, ICS Board, Suffolk and Essex Joint Health Overview Scrutiny Committee and the Health and Wellbeing Boards

The plan would not be finalised or published until it had gone through the necessary assurance processes with NHS England and NHS Improvement and other forums within the ICS.

It was highlighted that oral health amongst children, which was not commissioned by the CCG but by NHS England, was reported as the highest cause of inpatient admissions.

It was suggested that the Plan include more descriptive narrative in respect of Primary Care Networks and Integrated Neighbourhood Teams/Localities. The need for consistency of terminology across the CCGs was again emphasized.

**The Committee noted** the update.

## **19/66 PRIMARY CARE ESTATES STRATEGY FRAMEWORK**

The Committee was provided with an overview of the proposed framework which would be used to develop an ICS-wide Primary Care Estates Strategy.

The current CCG Strategic Estates Plan was developed in 2015 in conjunction with NHS Property Services. The existing estates plan provided an overview of the existing estate, opportunities for redevelopment/relocation and options around disposals up until approximately 2019. The Estates plan had now reached the end of its life and the social, environmental, political, economic and regulatory background had moved on since its development. A new strategy was needed to ensure the health system was able to deliver the right level of care in the right places for its population.

In order to ensure that primary care was planned and developed in a way that not only met with the requirements and demands of the local population, but also aligned with the wider acute, community, mental health and alliance strategies, it was proposed that a system-wide Primary Care Estates Strategy be developed.

Prior to the development of the strategy a framework had been developed for approval by both officers and the Primary Care Commissioning Committee. Whilst there would be ample opportunity to input and amend the strategy as it was developed it was important to make sure that the strategy started moving in the right direction. The framework had been reviewed and approved by the CCGs Primary Care Estates Operational Group and was attached to the report at Appendix 1.

The framework identified four key areas for the strategy, with a fifth section to facilitate review of the delivery and success of the plan. The four areas identified were;

- Strategic context and local drivers (Background and drivers)
- Overview of Current PC Estate (Where are we now)
- Vision for primary care estates (Where do we want to be)
- Opportunities and developments (How are we going to get there)

It was proposed that development of the estates strategy would incorporate the engagement of system wide stakeholders including. but not limited to, acute and community providers, mental health providers, GP's and Primary Care Networks, Patient Participation Groups, Local Authorities, Health Watch etc.

The Committee was informed of the direction of travel for more care to be provided outside

the hospital setting, and of national exploration of future estates funding flows going through Primary Care Networks.

There was concern that there were currently too many strategies and that new ones should be developed with an Alliance focus. There should perhaps be one over-arching strategy with separate chapters such as estates. It was felt that a different approach was required.

Having considered the report, and with the above in mind, **the Committee approved** the framework and suggested that a different, more Alliance based approach be taken to further development of the strategy. **It was requested** that a draft outline strategy be presented to the Committee in November 2019.

**19/67 DATE OF NEXT MEETING**

The next meeting was scheduled to take place on *Tuesday, 26 November 2019 from 2.00pm-4.00pm at Two Rivers Medical Practice, 30 Woodbridge Road East, Ipswich, Suffolk*

**19/68 QUESTIONS FROM THE PUBLIC**

No questions were received.

Unconfirmed



**IPSWICH & EAST SUFFOLK CCG – PRIMARY CARE COMMISSIONING COMMITTEE  
ACTION LOG: 22 October 2019 (updated)**

MINUTE	DETAILS	ACTION	BY WHOM	TIMESCALE/UPDATE
<b>Meeting of 21 May 2019</b>				
19/41	Public Questions	A Patient Participation Group Chair highlighted that recent NHS changes in respect of the development of East Suffolk and North Essex NHS Foundation Trust, Primary Care Networks, Integrated Neighbourhood Teams, and the introduction of Care Navigators and Physician Associates, was very confusing for patients. The Committee was asked to consider the development of communications to explain the recent changes and initiatives. The Committee requested that the CCG's Chief Officer and Communications Teams consider the development of such communications.	Chief Officer Team	22/10/19 – ongoing. Healthwatch was assisting with the development of communications. The Committee noted that a patient conference was scheduled to take place the following week. Whilst it was noted that regular newsletters were already circulated to patient participation groups it was suggested that consideration should be given to development of a communications action plan.
<b>Meeting of 23 July 2019</b>				
19/55	Questions from Members of the Public	a) Alan Rose, Patient Participation Group (PPG) member, Felixstowe, advised that Felixstowe PPGs felt some degree of disconnect from Healthwatch and Healthwatch representatives in attendance agreed to attempt to address the situation going forward. Circulation of the Healthwatch GP report to PPGs was welcomed.  b) The Chief Operating Officer agreed to raise the issue of lone attendance at first dementia assessments with the Dementia Forum and report back.	Luke Bacon/ Mike Ogden  Maddie Baker-Woods	Ongoing
<b>Meeting of 22 October 2019</b>				
19/61	Primary Care Networks – An Update	Any impact on integrated neighbourhood teams or localities was, as yet, unknown and it was agreed that further information be provided for the next update. There was a request, that in order to minimise confusion in respect of the terms of 'integrated neighbourhood teams' and 'localities' that there be consistency in respect of terminology across the CCGs.	David Brown	

MINUTE	DETAILS	ACTION	BY WHOM	TIMESCALE/UPDATE
19/63	Workforce Update	Having suggested that work be carried out to increase communication and promote the local area, which should include the promotion of training resources, it was agreed that the issue be fed back to the Alliance.	Maddie Baker Woods	
19/66	Primary Care Estates Strategy Framework	Having considered the report, and with the above in mind, the Committee approved the framework and suggested that a different, more Alliance based approach be taken to further development of the strategy. It was requested that a draft outline strategy be presented to the Committee in November 2019	Daniel Turner	Deferred to February 2020



**PRIMARY CARE COMMISSIONING COMMITTEE**

<b>Agenda Item No.</b>	<b>06</b>
<b>Reference No.</b>	<b>IESCCG PCCC 19-30</b>
<b>Date.</b>	<b>26 November 2019</b>

<b>Title</b>	<b>Primary Care Estates- Investment and Revenue Implications</b>
<b>Lead Officer</b>	Amanda Lyes, Director of Corporate Services and System Infrastructure
<b>Author(s)</b>	Daniel Turner, Estates Development Manager
<b>Purpose</b>	To provide the committee's with an overview of the proposed service charge policy which has been developed by NHS England.

**Applicable CCG Clinical Priorities:**

<b>1.</b>	To promote self care	
<b>2.</b>	To ensure high quality local services where possible	X
<b>3.</b>	To improve the health of those most in need	
<b>4.</b>	To improve health and educational attainment for children & young people	
<b>5.</b>	To improve access to mental health services	
<b>6.</b>	To improve outcomes for patients with diabetes to above national averages	
<b>7.</b>	To improve care for frail elderly individuals	
<b>8.</b>	To allow patients to die with dignity and compassion and to choose their place of death where appropriate	
<b>9.</b>	To ensure that the CCG operates within agreed budgets	X

**Action required by Primary Care Commissioning Committee:**

To consider and discuss the service charge policy and determine the extent to which they wish to implement it across Ipswich and East Suffolk and West Suffolk CCGs

## **1. Purpose**

- 1.1 To provide the Committee with an overview of the recent service charge policy which has been developed and released by NHS England as part of their update of the 'Primary Medical Care Policy Guidance Manual and the options around adoption of this policy across the CCGs.

## **2. Background**

- 2.1 Directions 46 & 47 of 'The National Health Service (General Medical Services – Premises Costs) Directions 2004 and 2013 (PCDs) enable GP practices to submit a claim to the Clinical Commissioning Group, for support in the payment of both running and service charge costs associated with their premises for the delivery of their GMS contract. The Directions are quite explicit in the items which a practice cannot seek reimbursement and these fall within one of four categories:
  - i. Fuel and electricity charges;
  - ii. Insurance costs;
  - iii. Costs of internal or external repairs; and
  - iv. Building and grounds maintenance costs,.
- 2.2 Any costs which can be deemed to fall within one of these categories must be excluded from a claim for financial assistance. However any other costs associated with the running of the premises can be submitted to the CCG under a claim for financial assistance. Where a claim is submitted, the CCG must consider this and, in appropriate cases, having regard to its budgetary targets, grant that application.
- 2.3 Applications for reimbursement of these costs will be associated with practices which are within shared multi tenanted buildings as they will likely be incurring costs beyond those listed above (i-iv).
- 2.4 In addition whilst some Directions within the PCDs prescribe a time limit within which a claim must be submitted, Directions 46 & 47 do not. Therefore Directions 58 (for claims under the 2004 Directions) and 53 (for claims under the 2013 Directions) apply, which allow a practice to submit a claim for up to 6 years back dated reimbursement.
- 2.5 Whilst the provision for reimbursement has been within the PCDs since at least 2004, it does not appear that practices have taken the opportunity to seek assistance with these costs until very recently. Similarly NHS England has only published guidance via the form of the service charge policy in 2019.

## **3. Policy detail**

- 3.1 The policy has been developed to try and provide both the CCG and GP practices with guidance around a number of key areas which the Directions do not provide any information on:
  - The period financial assistance should be provided over
  - What triggers a review
  - A system for prioritisation in light of budgetary targets
  - If financial assistance being requested can be mitigated
- 3.2 The policy sets down a number of key principles which each party needs to accept and follow; these are summarised below:

#### **4. Commissioners will**

- Prioritise applications from GP Contractors in LIFT, NHS PS or NHS Trust buildings as these typically attract higher service charge costs
- Only consider applications which pass through the eligibility criteria check gateways
- Offer short term financial support towards premises running costs where there is evidence their practice expenses are significantly higher than the latest published averages as a result of high service charge costs.
- Discontinue financial support towards premises running costs and/or service charges after a 12 month period, where the true costs pressure does not relate to service charge expenses.
- Have no direct involvement in managing service charge costs, but will require evidence that GP contractors and landlords have taken appropriate steps to mitigate costs.
- Have interest in both maintaining the viability of the practice and safe guarding tax payers monies to ensure value for money is delivered
- Use the latest available GP Earning and Expenses report to benchmark average PMS/GMS GP contractors earnings to expenses ratios
- Take into account changes in income and expenditure
- Always use the average previous year's annual service charge costs
- Test a range of alternative inputs to its model to establish which variables provide the best match to enable the GP contractor to attain average PMS/GMS contract earnings.

#### **5. GP Contractors will**

- Agree to full disclosure of income and expenditure on an open book and annual basis. If they do not wish to partake in an annual review they will need to propose a one off fixed term support package, which demonstrates as phasing out of financial assistance.
- Not seek to occupy an unreasonable amount of space, taking in to account their potential list size, and undertake to share space to mitigate costs.
- Take responsibility for assessing the potential for growing their practice list and develop associated trajectory over the relevant time period.
- Agree to negotiate and sign a lease at the earliest opportunity whilst seeking assurance from the landlord service charge costs being levied are fair & reasonable.
- Take responsibility for maximising their NHS income so that the burden of use of public monies for service charge assistance is reduced.
- Take responsibility for minimising their practice expenditure by ensuring cost effectiveness and value for money spend.
- Demonstrate through a clear action plan how they intend over a reasonable period of time (deemed to be 12 months) to optimise their income and reduce their expenditure, where there is evidence that their practice expenses are significantly higher than the latest published averages.

#### **6. Landlords/head lease holders will**

- Ensure proposed service charge costs being levied are fair and reasonable and they have a clear strategy to drive down service costs and provide associated evidence to their tenants in accordance with RICS Code of Practice
- Enable space to be used flexibly
- Allow GP contractors to procure their own services where it is practicable to do so

A full copy of the policy is provided in Appendix 1.

## **7. Eligibility and financial model assessment**

- 7.1 NHS England has produced a comprehensive spreadsheet that must be completed by the GP Contractor and forms the basis of their claim for financial assistance. In order for a claim for financial assistance to be eligible for consideration, the total practice expenses to total practice income (expressed as a percentage) for the most recent financial year must be greater than the published average 2016/17 Expenses to Earnings ratios for GP Contractors in the UK for a similar contract type. The practice should also have had no serious contract breaches for any reason since 1 April 2013. They can make a statement of mitigation if they had any serious breaches.
- 7.2 If the practice has a claim which is considered to meet the initial criteria they are required to complete tabs 3 & 4 on the spreadsheet. In completing these two tabs they must provide the following information.
- Full income and expenditure for the most recent financial year (across all sites)
  - Full disclosure of service charge costs paid
  - Baseline income must be separated from other income such as that received through QOF, Enhanced Services, non-NHS organisations, reimbursements etc.
  - A clear action plan on how it intends, over a reasonable period of time, to optimise its income and reduce its expenditure to align broadly with published UK averages for 2016/17 (or more recent where available)
  - How it plans to increase its share of the service charge cost and reduce liability of the CCG to provide financial assistance. If it cannot increase its share of the costs it must provide evidence as to why.
- 7.3 The practice income and expenditure will then be compared with the published 2016/17 UK averages for GMS and PMS to determine if the practice is performing broadly in line with these averages. Based on the previous years' service charge costs input by the practice the spreadsheet will determine the level of financial assistance being sought by the practice from the CCG. The spreadsheet allows for the figures to be adjusted to ensure the practice is not being put in a disadvantaged or advantageous position to that of a similar practice.
- 7.4 If, through this process, the practice is deemed to be eligible for financial support, a paper is then prepared and presented to Part 2 of the Primary Care Commissioning Committee for consideration. If a decision is made to provide financial assistance a formal agreement is signed by both the practice and the CCG which will be subject to annual review.
- 7.5 The service charge policy has been reviewed and considered acceptable by the Primary Care Estates Operational Group.

A hyperlink to the Service charge spread sheet is provided in appendix 2

## **8. Recommendation**

The Committee is invited to consider if they would want to implement the service charge policy across Ipswich & East Suffolk and West Suffolk CCG's either in part or in full.

## Premises Running Costs and Service Charges

### POLICY FOR CONSIDERATION OF APPLICATIONS FROM GP CONTRACTORS FOR FINANCIAL ASSISTANCE TOWARDS PREMISES RUNNING COSTS & SERVICE CHARGES

#### PURPOSE OF THE POLICY:

To provide a consistent methodology that is fair, transparent and equitable, for primary care Commissioners to consider formal applications for financial assistance towards premises running Costs and service charges in line with the NHS (GMS – Premises Costs) Directions 2013, Part 5 Directions 46 and 47.

#### 1.1 Introduction

- 1.1.1 The NHS (GMS – Premises Costs) Directions 2013, dated 28 March 2013, Part 5 Directions 46 and 47 enable GP contractors to request financial assistance from the Commissioner towards premises running costs and service charges that are not reimbursable elsewhere under the Directions. The Commissioner is required to consider such applications and, subject to budgetary targets, to approve them.
- 1.1.2 Applications for financial assistance, under direction 46, in respect of premises running costs, may include costs relating to fuel and electricity charges, building insurance costs, costs of internal or external repairs and/or plant, building and grounds maintenance costs.
- 1.1.3 Direction 47 offers two methods for calculating the amount of financial assistance towards service charges that the Commissioner may consider:
- 1.1.4 GP contractors are required to declare their previous year's average premises running costs (for the same period for which service charge support is applied for), which are then deducted from the financial assistance to be paid by the Commissioner towards service charges.
- 1.1.5 There's a 40% deduction, where information regarding the previous year's average premises running costs is not given/available, from the service charge costs otherwise payable by the Commissioner.
- 1.1.6 What the above provisions take no account of is the period in which financial assistance should be provided; what the trigger(s) for a review might be; applications that the Commissioner might prioritise over others in light of other budgetary targets; or whether the financial assistance being requested can be mitigated.
- 1.1.7 This policy seeks to address these issues.

## 1.2 Principles

1.2.1 In order for an application for financial assistance to be considered by a primary medical care commissioning organisation, the following principles need to be accepted and adopted by specified stakeholders:

### **Commissioners will:**

- 1.2.2 Prioritise formal applications from GP contractors that have already been made or those from practices proposing to occupy LIFT, NHS PS (Property Services), or NHS Trust buildings on a head or sub/under lease basis, in recognition of the Commissioner's budgetary targets. This does not preclude GP contractors in other tenancy arrangements or those considering entering into new tenancy arrangements making an application to primary care commissioners for financial assistance towards their premises running costs or service charges, but recognises that higher service charge costs are more typically evidenced by practices occupying or proposing to occupy NHS owned or head leased premises. This prioritisation is further evidenced within the local estates strategies, developed by CCGs with a wide range of local stakeholders, which seek to maximise use of existing public estate.
- 1.2.3 Only consider applications that pass through the eligibility criteria check gateway (section 12.3.1 refers). This enables primary care commissioners to prioritise applications that demonstrate they have the greatest need, which in turn ensures that a GP contractor does not waste their time on completing and providing information when ultimately, primary care commissioners are unable to support their application.
- 1.2.4 Make recommendations on applications that have passed through all gateways (please refer to section 12.3.3 below) to the relevant CCG Part 2 Primary Care Commissioning Committee. Applications can take a considerable time to process, should they be subsequently approved, back claims will be with effect from the date that the original application was made.
- 1.2.5 Offer short term financial support towards premises running costs and/or service charges to GP contractors where there is evidence that their practice expenses are significantly higher than the latest published averages, as a result of high service charge costs and other practice expenses. In this eventuality, a GP contractor must be prepared to put in place a clear action plan, demonstrating that over the next 12 months, it will optimise its income and reduce its expenditure. A further assessment as to whether a GP contractor should remain entitled to further financial support will be undertaken one year on by re-running the financial assistance model, subject to a GP contractor's wish to continue to request such support.

- 1.2.5.1 Discontinue financial support to GP contractors towards premises running costs and/or service charges after a 12 month period, where the true cost pressure does not relate to service charge expenses. GP Contractors can apply for further support under Section 96 of the National Health Services Act 2006.
- 1.2.5.2 Have no direct involvement in managing service charge costs but will require evidence that GP contractors and landlords/head leaseholders have taken appropriate steps to mitigate costs. Steps taken by the incumbents may include, but are not limited to: a formal meeting or correspondence with the landlord or head leaseholder during which the service charge costs were explained and justified. GP contractors should also seek assurance from the landlord/head leaseholder that the service charge costs demonstrate value for money and deliver soft and hard maintenance, in the interests of good estate management and following the principles within the RICS' Code of Practice – Service charges in commercial property. The current GP contractor should also show that they have analysed their own service expenditure to identify areas where costs can be reduced.
- 1.2.5.3 Have interest both in maintaining the viability of its practices and safeguarding tax payer's monies to ensure value for money is delivered.
- 1.2.5.4 Use the latest available GP Earnings and Expenses report currently published by NHS Digital to benchmark average PMS/GMS GP contractor's earnings to expenses ratios, which are used as a yardstick to ensure fair and reasonable application.
- 1.2.5.5 Take into account changes in income and expenditure, advising GP contractors about any outlying (based on the above NHS Digital report) costs in the process.
- 1.2.5.6 Always use the average previous year's annual service charge costs (where applicable) as the practice's starting contribution to new service charge costs, should a case be made for service charge support. Whilst there is a provision to assume 40% of service charge cost is paid by a GP Contractor in the event where no historical information is available, the model assesses financial assistance required by the GP Contractor based on actual cost projections and Expenses and Income ratios.
- 1.2.5.7 Test a range of alternative inputs to its model to establish which variables provide the best match to enable the GP contractor to attain average PMS/GMS contract earnings.
- 1.2.6 In light of the number of variables that can impact upon a GP contractor's ongoing need for financial support towards premises running costs and service charges, these would normally be reviewed on an annual basis, when the relevant information is available, reconciling costs back to the last review period.

### **1.2.7 GP Contractors will:**

- 1.2.7.1 Agree to full disclosure of income and expenditure on an open book and annual basis. Should GP contractors not wish to be party to an annual review, they will need to propose a one off fixed term support package, which demonstrates a phasing out of financial assistance, taking into account the known variables.
- 1.2.7.2 Not seek to occupy an unreasonable amount of space, taking into account their potential list size; and undertake to share space to mitigate costs, wherever this is practicable.
- 1.2.7.3 Take responsibility for assessing the potential for growing their practice list and develop the associated trajectory over the relevant time period.
- 1.2.7.4 Agree to negotiate and sign a lease at the earliest opportunity, whilst seeking assurance from the landlord/head leaseholder that the service charge costs being levied are fair and reasonable, in compliance with section 12.2.2.6.
- 1.2.7.5 Take responsibility for maximising their NHS income by providing GP services commissioned by local and national NHS and Local authority commissioners within their sphere of competence, resources and affordability, so that the burden of use of public monies for service charge assistance is reduced.
- 1.2.7.6 Take responsibility for minimising their practice expenditure by ensuring cost effectiveness and value for money spend.
- 1.2.7.7 Demonstrate through a clear action plan agreed with support from the LMC (as necessary), how they intend, over a reasonable period of time (deemed to be 12 months), to optimise their income and reduce expenditure, where there is evidence that their practice expenses are significantly higher than the latest published averages.

### **1.2.8 Landlords/Head Leaseholders will be expected to:**

- 1.2.9 Ensure the proposed service charge costs being levied are fair and reasonable, and they have a clear strategy to drive down service costs; and provide associated evidence to their prospective tenant/occupier in accordance with the RICS' Code of Practice – Service charges in commercial property.
- 1.2.10 Enable space to be used flexibly to enable GP contractors to mitigate costs, where possible.
- 1.2.11 Allow GP contractors to procure their own services (such as cleaning) where it is practicable to do so, subject to the former providing assurance that their specification will comply with life cycle requirements.

### 1.2.12 **Expectation management:**

1.2.12.1 Should there be evidence that a landlord is not prepared to fulfil the expectations detailed in 12.2.5.1 to 12.2.5.3, this will not – in principle - prejudice a GP contractor's application for financial support towards premises running costs and service charges. However, it is likely to delay the processing of an application until the information required to complete it is available.

### 1.2.13 **Evidence required to demonstrate application of Principles:**

1.2.13.1 An expression of interest or application shall normally be considered when the steps identified in 12.2.7.1.1 to 12.2.7.1.4 have been evidenced:

1.2.13.1.1 Meetings and/or correspondence between the landlord/head leaseholder and the GP contractor which include full disclosure of soft FM costs backed up with supporting evidence

1.2.13.1.2 Agreement that the footprint that the GP contractor occupies or wishes to occupy is sufficient to meet their current service provision and future potential provision

1.2.13.1.3 Confirmation that key support service related matters such as cleaning services have been discussed and agreed

1.2.13.1.4 Evidence that the impact of procured soft FM services has been discussed in the context of value for money

## 1.3 **The Model**

### 1.3.1 **Eligibility criteria:**

1.3.2 Questions to help establish eligibility should be answered on Tab 2 in Annex 2 of the FMT (Financial Model Template).

1.3.3 Total practice expenses to total practice income (expressed as a percentage) for the most recent financial year must be greater than the published average 2016/17 Expenses to Earnings ratios for GP Contractors in the UK for a similar contract type (see FMT, Annex 2, Tab 5). "The expenses to earnings ratio is a measure of the proportion of an individual's gross earnings that is consumed by business expenses. For ease of understanding it is expressed as a percentage throughout this report."<sup>1</sup> Note: "Full time and part time GPs are included. Figures are irrespective of working hours." "Earnings and expenses results relate

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<sup>1</sup> GP Earnings and Expenses 2016/17 by NHS Digital<sup>2</sup>, published 30 August 2018, p. 9.

to both NHS and private work. It is not possible to provide an NHS/private split using HMRC as a data source as most GPs submit a Self-Assessment tax return which contains information on all of their self-employment earnings while practising as a GP, but which cannot differentiate between NHS and private earnings. GPs can perform both NHS and private work both inside and outside of practice, including the NHS Out of Hours service.” Private income is identified as a very small percentage of average GP income – based on the England data collection “As a guide to NHS/private earning proportions, the average NHS superannuable income for GPMS contractor GPs was 94 per cent of income before tax in 2014/15 which is the latest year for which pensions data are available.” If the value of work being undertaken by a GP partner outside of their contractual commitment affects the total practice expenses to total practice income ratio, such that it is significantly greater than the relevant GMS, PMS or APMS benchmark ratio (as appropriate), NHS England reserves the right to exclude additional practice expenses relating to this (e.g. locum costs to cover GP partner’s practice sessions). The value of outside clinical work/advice should be included in the expenditure incurred by the practice. Primary Care commissioners recognise that there may be circumstances that impact on the expenses/income ratio that could exclude a practice’s application for consideration for financial assistance towards service charges; these issues will always be evaluated on a case by case basis.

1.3.3.1 The practice should have had no serious contract breaches for any reason since 1 April 2013. The practice can make a statement for mitigation if they have had any serious contract breaches since 1 April 2013.

1.3.3.2 Should the above criteria not be met, or the practice has not yet provided acceptable explanations for mitigation, an application will not be considered any further.

**1.3.4 Financial Model template:**

1.3.5 For the purpose of this exercise, a contract is considered as a whole. In other words, where a practice operates from more than one site, the combined income and expenses should be entered on the template. Similarly, where two or more practices are merging, the estimated combined income and expenses of the new practice should be entered on the template.

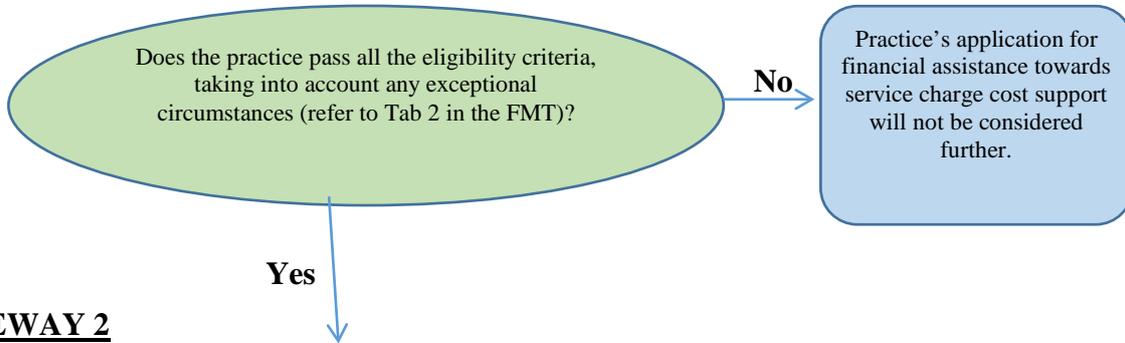
1.3.6 The practice is required to populate the attached “I&E” template (Tab 3 in the FMT) declaring their income and expenditure for the most recent financial year, including full disclosure of service charge cost paid during the most recent financial year. Evidence of payment of service charges must be provided. If no service charges were paid, a statement is required stating the reasons why no service charge costs were paid during the most recent financial year. Applications where this applies will be evaluated on a case by case basis.

- 1.3.6.1 The practice must show baseline income separate from other income such as income received from QOF, Enhanced Services, non-NHS organisations, reimbursements, etc.
- 1.3.6.2 The practice income and expenditure will be compared with the published 2016/17 UK averages (Tab 5 in the FMT) for GMS and PMS practices to determine if the practice is performing broadly in line with these averages. An adjustment may be made for service charges based on the information provided by the practice since the UK average for service charge cost is not available.
- 1.3.6.3 On the "I&E" template (Tab 3 in the FMT), the practice should demonstrate through a clear action plan how it intends, over a reasonable period of time, as agreed with the commissioner, to optimise its income and reduce its expenditure, where applicable, to align broadly with the published UK averages for 2016/17 (Tab 5 in the FMT) (or more recent when available).
- 1.3.6.4 On the Service Charge template (Tab 4 in the FMT), the practice should further demonstrate how it plans to increase its share of the service charge cost and reduce the liability of the primary care commissioner to provide financial assistance. This can be done in fixed percentage/value increments each year, or based on list growth or another plan tailored for the practice. The practice is advised to note the impact of its projections on its Expenses to Earnings ratios. Where a practice cannot increase its share of the service charge cost, it must give reasons why this is not possible. Note that the primary care commissioner's liability for financial assistance for Service Charge support can never be higher than the total Service Charge cost to the practice.
- 1.3.6.5 The figures mentioned above will be reviewed on an annual basis in the interest of the practice, primary care commissioner as well as the taxpayer. This includes the income and expenditure, service charge cost as well as the comparison with UK averages where applicable. The projected reduction in primary care commissioner's liability for financial assistance for service charge cost will also be assessed annually to evaluate whether it is viable or not for the practice to be responsible for a larger share, and ultimately 100%, of the total service charge cost. The practice should notify the primary care commissioner of any significant changes and provide an updated FMT to enable the re-evaluation of financial assistance for service charge cost. If there are no significant changes, the practice must provide the primary care commissioner with proof of payment of the most recent years' service charge costs in order to compare that with the FMT submitted previously. Primary care commissioners will reconsider financial assistance for service charge cost support to a practice if there are significant changes to the FMT as well as actual service charge costs.

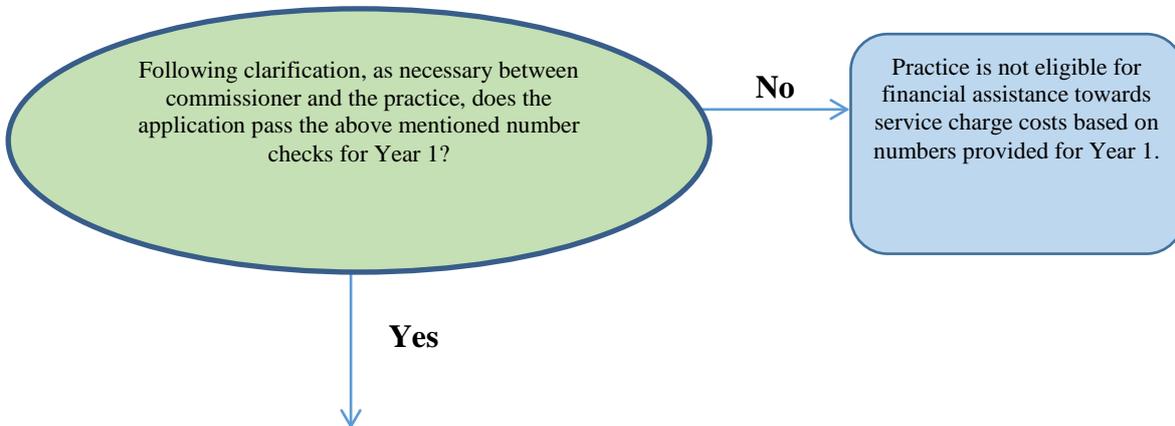
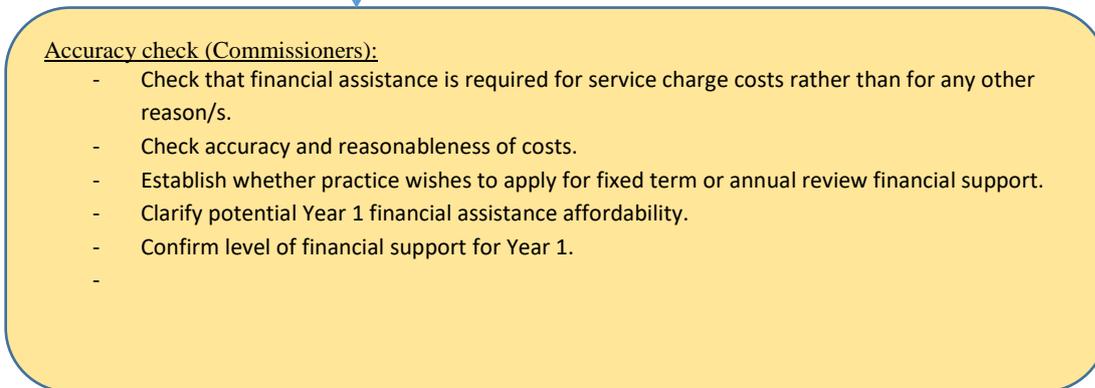
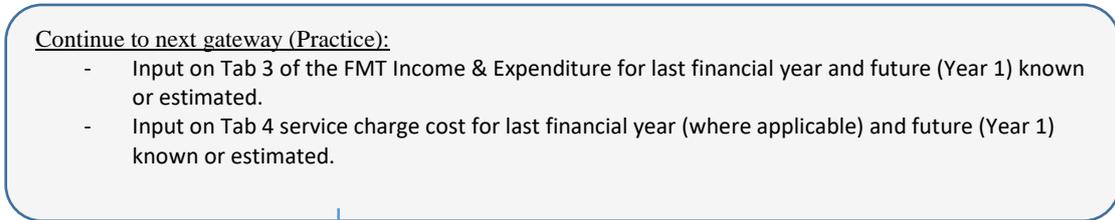
1.3.6.6 Where a practice chooses not to disclose its income and expenditure information on an annual basis, it will need to propose a fixed term financial assistance package for service charge costs. The practice will still be required – in the first instance – to demonstrate that it meets the eligibility criteria to access financial assistance, and must also provide proof of payment of the most recent years' service charge costs (where applicable). The practice will need to demonstrate a reduction in required service charge support taking into account known variables such as changes in weighted list size, baseline price, other income, actual service charge costs, other expenditure, national averages and other variables that may impact the financial viability of the proposal. At the start of each financial year and while financial assistance is required, the practice must provide proof of payment of the most recent years' service charge costs to the commissioner in order to compare that with the proposed financial assistance package, regardless of its agreement to a fixed term package. The commissioner will reconsider its financial assistance for service charge costs to the practice if there are significant changes to the proposed package and actual service charge costs. Financial assistance towards service charge costs will only be reimbursed based on actual service charge cost paid by the practice and not while there is a dispute between the practice and the landlord, and/or there is no lease in place and/or the service charge costs have not been agreed with the landlord following an increase in this cost.

## 1.4 Process flowchart

### GATEWAY 1



### GATEWAY 2



**GATEWAY 3**

Continue to next gateway (Practice):

- To complete Tabs 3 & 4 with projections post Year 1 based on either fixed term or annual review request for financial assistance towards service charge support.

Accuracy check (Commissioners):

- Check that financial assistance is required for service charge costs rather than for other reason/s.
- Check accuracy and reasonableness of costs.
- Confirm again whether practice wishes to apply for fixed term or annual review financial support.
- Clarify potential affordability of financial assistance post Year 1.
- Confirm level of financial support for after Year 1.
- 

Following clarification, as necessary between commissioner and the practice, does the application pass the above mentioned checks on projected numbers after Year 1?

**No**

Practice is not eligible for financial assistance towards service charge costs based on current projections.

**Yes**

**GATEWAY 4**

Recommendation to the relevant CCG Part 2 Primary Care Commissioning Committee should be made. Subject to PCCC endorsement, a formal agreement must be signed between Commissioner and the practice, which will be subject to annual financial review of figures as applicable.

Appendix 2 FMT Service Charge Support

[FMT Service Charge Support](#)



**PRIMARY CARE COMMISSIONING COMMITTEE**

<b>Agenda Item No.</b>	<b>07</b>
<b>Reference No.</b>	<b>IESCCG PCCC 19-31</b>
<b>Date.</b>	<b>26 November 2019</b>

<b>Title</b>	<b>Primary Care Contracts and Performance Report</b>
<b>Lead Officer</b>	Maddie Baker-Woods, Chief Operating Officer
<b>Author(s)</b>	Caroline Procter, Primary Care Commissioning Manager
<b>Purpose</b>	To provide the committee with an overview of primary care information and update on primary care contracts where relevant .

<b>Applicable CCG Clinical Priorities:</b>		
1.	To promote self care	
2.	To ensure high quality local services where possible	X
3.	To improve the health of those most in need	
4.	To improve health & educational attainment for children & young people	
5.	To improve access to mental health services	
6.	To improve outcomes for patients with diabetes to above national averages	X
7.	To improve care for frail elderly individuals	
8.	To allow patients to die with dignity and compassion and to choose their place of death where appropriate	
9.	To ensure that the CCG operates within agreed budgets	X

<b>Action required by Primary Care Commissioning Committee:</b>
To consider and discuss the information provided and agree any appropriate actions required.

## **1. Purpose**

- 1.1 To update the Committee on contractual and performance related matters in respect of GP Practices and actions taken; to seek further recommendations and areas for consideration for the Primary Care team.

## **2. Primary Care Networks (PCNs)**

- 2.1 PCNs are beginning to build momentum, with a number of activities underway.
- 2.2 PCNs are beginning to recruit Clinical Pharmacists and Social Prescribing Link Workers as part of the Additional Roles reimbursement scheme. This has had some success in some PCNs but has raised issues relating to the availability and affordability of new staff and the need for clarity on some complex liability issues. The CCG has highlighted these issues with the regional and national NHS England teams and is working to support practices and PCNs as far as we can.
- 2.3 PCNs are beginning to explore options to best utilise the PCN Development Funds. The CCG has received a number of proposals to date. These requests have been considered by a small panel to ensure they meet the NHS England criteria. A number of schemes have been provisionally approved.
- 2.4 Three PCNs have been selected to work on a population Health Management programme with Optum and NECS (North East Commissioning Support unit). This comprehensive 20 week programme is expected to commence in January 2020 before being offered to all remaining PCNs. Systematic population health analysis allows the PCN to understand in depth their population's needs, including the wider determinants of health, and design interventions to meet them; acting as early as possible to keep people well and address health inequalities. The PCN's population health model needs to be fully functioning for all patient cohorts.
- 2.5 System partners will work with PCNs to design proactive care models and anticipatory interventions based on evidence to target priority patient groups and to reduce health inequalities.

## **3. Winter Local Enhanced Service (LES)**

- 3.1 The CCG has commissioned three winter schemes to provide additional support to patients over the winter period.
  - 1) A winter planning project to support patients suffering from moderate to severe chronic obstructive pulmonary disease (COPD). Currently 19 practices have signed up to deliver this proactive service until February 2020.
  - 2) A winter check scheme for housebound patients aged 65+. This is to improve patient outcomes by delivering a winter check through a home visit. This is currently being piloted in two PCNs and will be running between November and February 2020. An evaluation will take place after the pilot to determine effectiveness.
  - 3) GP practices are asked to deliver an additional ward round into care homes over a 2-week period. This winter scheme has been commissioned successfully over the last 3 years.

#### **4. Prescribing and Medicines Management**

- 4.1 **Prescribing budget:** At the end of 2018/19, GP prescribing showed an under spend against budget of £1.7million (3%). Month five figures for 2019/20 show an over spend against budget of £326k (1.4%).
- 4.2 There are still ongoing cost pressures from national stock shortages, Drug Tariff price increases and Category M pressures. It is anticipated that IESCCG will end the year over budget and a paper is due to be submitted to Commissioning Governance to look at alleviating the cost pressures on practices.
- 4.3 Ongoing practice review meetings have been set up with practices who are significantly over budget to discuss the practice prescribing plans and provide ongoing support
- 4.4 **Antibiotic prescribing:** IESCCG are on track to meet the targets under the CCG Improvement and Assessment Framework (CCG IAF) for antibiotic prescribing in 2019/20. Antibiotic prescribing remains a key safety and quality focus for 2019/20.
- 4.5 **QIPP delivery:** At month five of 2019/20, GP prescribing has delivered a total of £397k cost efficiency savings against a YTD target of £398k.
- 4.6 **Medicines Management team priorities:** The team is prioritising work to help reduce antibiotic usage and encourage formulary adherence; reduce the use of medicines of low clinical value and medicines that can be purchased over the counter (as per NHSE guidance); and optimise the use of appliances.

#### **Actions – Ongoing:**

- Work with ICS primary care colleagues to align CCG guidelines and protocols to ensure a consistent message across primary care. Work is also underway to consolidate the shared care agreements to produce one ICS-wide agreement for each shared care drug.
- Work to align the medicines formularies across the ICS and promote the use of the formulary website and app.
- Discussion of practice antibiotic prescribing at practice visits and training events, including the quality premium metrics and use of broad spectrum antibiotics.
- Encouragement for practice level audits against the antibiotic formulary to be undertaken
- Individual meetings with all practices to introduce their aligned CCG pharmacist and discuss ongoing support.
- Networking with existing practice based pharmacist with a view to network with newly appointed PCN pharmacists

#### **5. Performance Targets**

##### **5.1 Severe Mental Illness (SMI) Physical Health Checks**

The 2019/20 LES has been live since June. As at quarter two, 41.5% of annual physical health checks have been completed for patients on practice SMI registers. The NSFT SMI Physical Health Check team has been working closely with primary care since June to establish which patients under secondary care need to take physical health checks.

Practices are also referring primary care patients who are not engaging with the team so that they can carry out assertive outreach for those patients with the aim of either completing the health check themselves or encouraging them to engage with primary care.

The target for completed health checks is 60% by March 2020.

## 5.2 Learning Disabilities (LD) Health Checks

The CCG continues to work closely with practices to support them in delivering health checks for people living with Learning Disability in Ipswich and East Suffolk.

Primary Care Learning Disability Liaison nurses employed by NSFT across East and West Suffolk are working with practices to review their LD register to identify patients who are either not appropriate for inclusion on the register or who should be included due to their diagnosis. They are working closely with Suffolk County Council and the information that they hold regarding this cohort of patients. They continue to offer support and guidance to primary care staff when appropriate.

Health checks are a key part of the LeDeR (Learning Disabilities Mortality Review Programme) and any learning from this process is fed through to both primary care and the Liaison nurses. Focusing on the quality of health checks is a key priority going forward.

5.3 **LD Health Checks Completed in Q2: 20.8%** (up 3% on same period last year and our best ever Q2)

5.4 **LD Health Checks Completed in Q2 YTD: 34.4%** (up 6.5% against same period last year, again our best ever Q2 cumulative performance).

The CCG target for health checks completed is 75% by March 2020.

## 5.5 Dementia coding

### Ongoing actions

- The CCG has engaged with Community Memory Assessment Service (CMAS) to look at ways of increasing acute hospital assessment and referral activity to result in increased diagnosis
- The first East Suffolk Dementia Operational Group workshop took place to co-ordinate delivery of a dementia alliance to build system foundations for the future.
- The team has re-introduced and promoted the use of dementia diagnosis tools to support Primary care/Care Home Liaison and Care Homes to work together to raise concerns and improve Dementia Diagnosis Rate (DDR).
- Continued engagement and working with Suffolk County Council Lead for supported living schemes in Ipswich and East Suffolk to raise dementia awareness
- Five collaborative practice visits (CCG, CMAS, REACT, DIST Dementia Together) have been undertaken to promote a whole system offer. Learning and feedback from these meetings has been cascaded to wider stakeholders.
- The CCG has developed a simple dementia data dashboard to provide an overview and to monitor data
- Collaborative work with CCG care homes team, care homes and practices to review register and identify diagnosis gaps is on-going.
- We have produced and distributed “ why diagnose dementia leaflet” to practices
- Engagement with other CCGs – How they are getting it right and lessons learnt
- A protocol to support technicians and practices in identifying patients with potential dementia diagnosis has been developed.
- The CCG held a Dementia evening event in June 2019, it was well attended by 19 practices. There is a plan to hold another in January 2020.

## 6. Quality and Outcomes Framework (QOF)

- 6.1 QOF is the annual reward and incentive programme to focus GP services on particular quality indicators. It rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services.
- 6.2 QOF performance has recently been published for 2018/19. The average practice achievement across the CCG has increased over the last 2 years and demonstrates continuous quality improvement.
- 6.3 QOF overall achievement 18/19, by CCG compared to regional and national averages

	16/17 - Overall Achievement %	17/18 - Overall Achievement %	18/19 - Overall Achievement %
NHS IPSWICH AND EAST SUFFOLK CCG	98.05	98.09	98.84
NHS WEST SUFFOLK CCG	97.82	97.61	98.16
SUFFOLK AND NORTH EAST ESSEX STP	<b>97.24</b>	<b>97.13</b>	<b>97.55</b>
<b>ENGLAND</b>	<b>96.50</b>	<b>96.00</b>	<b>96.57</b>
NORTH EAST ESSEX CCG	96.01	95.50	95.42

**I&ES CCG:** Average achievement 552.51 (98.84% of points available - last year 98.09%)  
**NHSE:** 539.2

### Current Action:

- Review all those practices with a significant variance to help understand any underlying reason and provide support where necessary.

See Appendix 1 for a full breakdown of overall achievement, by practice

## 7. QOF Exception reporting

- 7.1 The QOF includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.
- 7.2 It is the responsibility of NHS England to review all declared QOF achievement reports prior to financial sign off.
- 7.3 The variance in rates across the CCG shows the lowest overall exception reporting rate of 2.82% and the highest 7.72%.
- 7.4 One of the elements of the PMS Development Framework requires that PMS practices remain at or below the England average (6.38%). All practices are within an acceptable range of variation.
- 7.5 QOF overall exception rates 18/19, by CCG compared to regional and national averages.

	16/17 - Overall Exception Rate (%)	17/18 - Overall Exception Rate (%)	18/19 - Overall Exception Rate (%)
NHS IPSWICH AND EAST SUFFOLK CCG	5.42	5.65	5.50
NHS WEST SUFFOLK CCG	5.59	5.73	5.57
SUFFOLK AND NORTH EAST ESSEX STP	<b>5.26</b>	<b>5.33</b>	<b>5.21</b>
<b>ENGLAND</b>	<b>5.83</b>	<b>5.99</b>	<b>6.38</b>
NORTH EAST ESSEX CCG	4.85	4.56	4.61

**8. Recommendation**

The Committee is asked to note the above information and consider any further appropriate actions.

## Appendix 1

<b>QoF ACHIEVEMENT - ALL DOMAINS - 18/19</b>			
<b>Ipswich and East Suffolk</b>			
	<b>17/18 - Overall Achievement %</b>	<b>18/19 - Overall Achievement %</b>	<b>% Change</b>
THE HOLBROOK AND SHOTLEY PRACTICE	100.00	100.00	0.00
STOWHEALTH	100.00	100.00	0.00
GROVE MEDICAL CENTRE	100.00	100.00	0.00
THE PENINSULA PRACTICE	100.00	100.00	0.00
THE NORWICH ROAD SURGERY	100.00	100.00	0.00
FRESSINGFIELD MEDICAL CENTRE	99.94	100.00	0.06
WICKHAM MARKET MEDICAL CENTRE	99.85	100.00	0.15
HADLEIGH BOXFORD GROUP PRACTICE	99.35	100.00	0.65
RAVENSWOOD MEDICAL PRACTICE	99.89	100.00	0.11
FRAMFIELD HOUSE SURGERY	99.88	99.97	0.09
THE DERBY ROAD PRACTICE	100.00	99.96	-0.04
ORCHARD MEDICAL PRACTICE	99.79	99.95	0.16
DR SOLWAY & DR MALLICK PRACTICE	99.95	99.89	-0.06
BARRACK LANE MEDICAL CENTRE	99.84	99.82	-0.02
LITTLE ST JOHN STREET SURGERY	100.00	99.80	-0.20
DEBENHAM GROUP PRACTICE	98.28	99.69	1.41
NEEDHAM MARKET COUNTRY PRACTICE	98.53	99.69	1.15
COMBS FORD SURGERY	99.52	99.64	0.12
FRAMLINGHAM SURGERY	97.70	99.57	1.87
TWO RIVERS MEDICAL CENTRE	99.17	99.43	0.26
WALTON SURGERY	97.02	99.37	2.35
HAVEN HEALTH	94.90	99.36	4.45
THE BIRCHES MEDICAL CENTRE	99.81	99.35	-0.45
THE CHESTERFIELD DRIVE PRACTICE	98.25	99.35	1.10
BILDESTON HEALTH CENTRE	99.47	99.24	-0.23
BURLINGTON ROAD SURGERY	99.28	98.93	-0.35
MENDLESHAM HEALTH CENTRE	96.49	98.87	2.37
<b>NHS IPSWICH AND EAST SUFFOLK CCG</b>	<b>98.09</b>	<b>98.84</b>	<b>0.75</b>
MARTLESHAM SURGERY	97.86	98.84	0.98
LEISTON SURGERY	98.17	98.80	0.63
FELIXSTOWE ROAD MEDICAL PRACTICE	98.44	98.68	0.25
<b>NHS WEST SUFFOLK CCG</b>	<b>97.61</b>	<b>98.16</b>	<b>0.55</b>
CHURCH FARM SURGERY	99.55	98.16	-1.40
IVRY STREET MEDICAL PRACTICE	87.39	97.82	10.43
DEBEN ROAD SURGERY	99.27	97.77	-1.50
HOWARD HOUSE SURGERY	97.42	97.29	-0.13
THE BARHAM & CLAYDON SURGERY	94.54	97.08	2.55
HAWTHORN DRIVE SURGERY	93.07	96.99	<b>3.92</b>
<b>EAST OF ENGLAND</b>	<b>96.06</b>	<b>96.60</b>	<b>0.54</b>
<b>ENGLAND</b>	<b>96.39</b>	<b>96.57</b>	<b>0.18</b>
IXWORTH SURGERY	96.43	95.58	-0.85
SAXMUNDHAM HEALTH CENTRE	92.69	95.38	2.70
CONSTABLE COUNTRY RURAL MEDICAL PRACTICE	93.63	94.89	1.25
EYE HEALTH CENTRE	98.27	94.40	-3.87



**PRIMARY CARE COMMISSIONING COMMITTEE**

<b>Agenda Item No.</b>	<b>08</b>
<b>Reference No.</b>	<b>IESCCG PCCC 19-32</b>
<b>Date.</b>	<b>26 November 2019</b>

<b>Title</b>	<b>Primary Care Networks Development Funds</b>
<b>Lead Officer</b>	Maddie Baker-Woods, Chief Operating Officer
<b>Author(s)</b>	Caroline Procter, Primary Care Commissioning Manager
<b>Purpose</b>	To provide the committee with update on PCN Development Funds

<b>Applicable CCG Clinical Priorities:</b>		
1.	To promote self care	
2.	To ensure high quality local services where possible	X
3.	To improve the health of those most in need	X
4.	To improve health & educational attainment for children & young people	
5.	To improve access to mental health services	
6.	To improve outcomes for patients with diabetes to above national averages	
7.	To improve care for frail elderly individuals	
8.	To allow patients to die with dignity and compassion and to choose their place of death where appropriate.	
9.	To ensure that the CCG operates within agreed budgets	

<b>Action required by Primary Care Commissioning Committee:</b>
To consider the PCN development fund proposals

## 1. Background

1.1 Implementing the NHS Long Term Plan requires the development of effective Primary Care Networks (PCNs). To help all PCNs mature and thrive, every STP and ICS needs to put in place high quality support.

### 1.2 NHS England's ambitions for PCNs over the next 5 years:

The development support offer should match the scale of our collective ambitions for PCNs. PCNs were established on the 1 July 2019. Looking ahead and towards 2023/24, PCNs should aspire to having done five things:

- First, **stabilised general practice**, including the GP partnership model
- Second, **helped solve the capacity gap** and improved skill-mix by growing the wider workforce by over 20,000 wholly additional staff as well as serving to help increase GP and nurse numbers
- Third, become a **proven platform for further local NHS investment**
- Fourth, **dissolved the divide between primary and community care**, with PCNs looking out to community partners not just in to fellow practices
- And fifth, systematically delivered new services to implement the Long Term Plan, including the seven new service specifications, and **achieved clear, positive and quantified impacts** for people, patients and the wider NHS.

### 1.3 NHS England's expectations of PCNs by March 2020:

With the support outlined, by March 2020 all PCNs should be able to:

- **Understand their own journey**: know where they are aiming to get to over the next five years, use a diagnostic process to establish development need, using a maturity matrix or similar tool, and put a development plan in place
- Be functioning increasingly well as a **single team**
- Be part of a '**network of PCNs**' that helps shape the STP/ICS plan to implement the Long Term Plan
- Formed clear and agreed **multi-disciplinary teams** with community provider partners
- Building on existing relationships, form **links with local people and communities** to understand how to work most effectively for their benefit
- Have made **100% use of their funding entitlement for additional roles** in line with national guidance
- Have started work on at least one **service improvement project** of some kind, linked to Long Term Plan goals
- Have started thinking about their **future estate needs**, jointly with community partners
- Be ready to deliver **new national service specifications** from April 2020

In practice, responsibility for ensuring effective support falls to primary care teams in CCG or ICS, working hand-in-glove with PCN Clinical Directors, and critically their wider community partners: community providers, the voluntary sector, and local government.

## 2. Update

2.1 The CCG has available £309,600 to enable the ambition of each PCN. This funding is recurrent although it is unclear on the allocation year on year.

2.2 The criteria to spend the funds is set out in the PCN development Support – Guidance and Prospectus developed by NHS England. It has been designed to help a PCN progress against the maturity matrix.

2.3 Funds should be spent in line with the NHS England prospectus and can be used for:

- PCNs to prepare for the 20/21 service specifications
- Backfill of clinical time
- Training and organizational development
- A local project or priority area
- Supporting the 6 domains of the maturity matrix

2.4 Funds should not be used for:

- Business as usual
- Things already funded by CCG or the GP contract
- Non PCN related
- Non transformation.

### 3. **PCN Development Plan proposals**

3.1 The CCG has received number proposals for funding. A small panel was convened with GPs and the primary care team to review each proposal to ensure it met the NHS England criteria

3.2 Following this review, the subsequent proposals have been approved to date; although some are pending further information.

PCN	Proposal	Amount
Felixstowe and Area	Organisational Development. There are a number of new staff and managers across the PCN practices and this funding would be invaluable in ensuring there are sufficient skills and capacity to deliver the objectives of the PCN. The proposal includes a comprehensive programme for 30 staff.	£9,500.09
Mid Suffolk and North West Ipswich	Organisational Development. Funding is seen as crucial in ensuring the 250+ staff that work in these 2 PCNs are fully engaged with the vision and objectives of PCN and aligned with Suffolk Primary Care and wider stakeholders	Approx. £15,000
DHG South	The proposal is to introduce group consultations within the PCN across the four practices and start by looking at diabetes care. Once established the model can be rolled out for other long-term conditions and could be used with secondary care to move follow-ups from the hospital into the community.	£12,200
North West Ipswich	Project management - The purpose of which is to support the integration and development of the PCN as a whole. The project manager would lead on the implementation of a number of PCN wide initiatives to improve the interoperability of systems, which would aid workforce sharing, and the delivery of PCN wide services.	Approx. £30,000
North West Suffolk	½ day stakeholder event or workshop, to include the wider INT partners.	TBC.

### 4. **Recommendation**

4.1 Note the above information and consider any further appropriate actions.



**PRIMARY CARE COMMISSIONING COMMITTEE**

<b>Agenda Item No.</b>	<b>09</b>
<b>Reference No.</b>	<b>IESCCG PCCC 19-33</b>
<b>Date.</b>	<b>26 November 2019</b>

<b>Title</b>	<b>Primary Care Delegated Commissioning- Finance Report</b>
<b>Lead Officer</b>	Jane Payling, Director of Finance
<b>Author(s)</b>	Wendy Cooper, Finance Manager (Primary Care-Ipswich & East Suffolk and West Suffolk CCGs)
<b>Purpose</b>	To provide the committee with an overview of the month seven Primary Care Delegated Commissioning Budget

<b>Applicable CCG Clinical Priorities:</b>		
<b>1.</b>	To promote self care	
<b>2.</b>	To ensure high quality local services where possible	
<b>3.</b>	To improve the health of those most in need	
<b>4.</b>	To improve health & educational attainment for children & young people	
<b>5.</b>	To improve access to mental health services	
<b>6.</b>	To improve outcomes for patients with diabetes to above national averages	
<b>7.</b>	To improve care for frail elderly individuals	
<b>8.</b>	To allow patients to die with dignity and compassion and to choose their place of death where appropriate	
<b>9.</b>	To ensure that the CCG operates within agreed budgets	X

<b>Action required by Primary Care Commissioning Committee:</b>
To note the report

## 1. Purpose

- 1.1 To provide the committee with an overview of the month seven Primary Care Delegated Commissioning Budget and other associated primary care budgets.

## 2. Key Points

- 2.1 At the end of month seven, the GP Delegated Budget spend was £523k over spent – please see the table below for a summary of key variances:

Application of Funds	YTD			Full Year			Variance Analysis
	Budget	Actual	Variance	Budget	Forecast	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	
General Practice - GMS	5,650	5,663	(13)	9,686	9,727	(41)	Variance due to list size increase
General Practice - PMS	17,864	17,870	(6)	30,624	30,768	(144)	Variance due to list size increase
Enhanced services	664	1,003	(338)	1,138	1,817	(678)	Variance relates mainly to PCN Participation DES and expected increase in LD Health checks
QOF	3,241	3,241	0	5,556	5,556	0	
Primary Care Network	113	210	(97)	194	473	(279)	Variance relates to PCN payments to Networks
Premises cost reimbursements	2,725	2,750	(25)	4,672	4,714	(42)	Variance relates to rent reviews
Other - premises costs	94	131	(36)	162	224	(63)	Variance due to increase in cost of clinical waste
Other List-Based Services (APMS incl.)	2,870	2,823	47	4,919	4,788	132	Benefit from in year seniority reduction and addit dispensing drs funding
Other - GP Services	49	103	(54)	84	(123)	207	PY benefit
<b>Primary Care Delegated Commissioning</b>	<b>33,270</b>	<b>33,794</b>	<b>(523)</b>	<b>57,035</b>	<b>57,943</b>	<b>(908)</b>	

Other Primary Care shows an under spend of £1,346k at the end of M7, as summarised in the table below:

Application of Funds	YTD			Full Year			Variance Analysis
	Budget	Actual	Variance	Budget	Forecast	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	
Local Enhanced Services	1,645	1,505	140	2,822	2,652	170	Variance primarily relates to PY benefit.
Primary Care Contingency	0	(791)	791	0	(791)	791	PY Benefits to offset Primary Care Delegated Commissioning over spend
GPFV	2,053	1,639	414	3,520	2,863	657	Variance relates to 19/20 under performance
<b>Other Primary Care</b>	<b>3,699</b>	<b>2,352</b>	<b>1,346</b>	<b>6,342</b>	<b>4,724</b>	<b>1,618</b>	

## 3. Risks / Opportunities

- 3.1 In M7 the CCG has identified the following additional opportunities amounting to £1,164k;

- Underspend on PCN roles reimbursement.
- Underperformance on the 19/20 GP+ contract.
- Remaining prior year benefit relating to GPFV Access funding has been transferred to Primary Care Contingency.

- 3.2 The contingency will be primarily used to offset the forecast overspend in the Primary Care Delegated Commissioning budget.

- 3.3 Other risks not reflected in the above full year forecasts are further increases in rent reimbursement, additional practice management support and an increasing number of claims for locum allowance for parental and sickness absence.

## 4. Recommendation

- 4.1 The Committee is asked to note the financial performance at month seven.

**IESCCG PRIMARY CARE COMMISSIONING COMMITTEE ANNUAL PLAN OF WORK:**

January	<b>25 February 2020</b>	March
	<ul style="list-style-type: none"> <li>• General Update</li> <li>• Primary Care Contracts and Performance Report</li> <li>• Finance Report</li> <li>• CQC Report</li> <li>• Primary Care Estates Strategy Outline</li> </ul>	
<b>28 April 2020</b>	May	<b>23 June 2020</b>
<ul style="list-style-type: none"> <li>• General Update</li> <li>• Primary Care Contracts and Performance Report</li> <li>• Finance Report</li> <li>• CQC Report</li> </ul>		<ul style="list-style-type: none"> <li>• General Update</li> <li>• Primary Care Contracts and Performance Report</li> <li>• Finance Report</li> <li>• CQC Report</li> <li>• Annual Plan of Work</li> <li>• Terms of Reference Annual Review</li> </ul>
July	<b>25 August 2020</b>	September
	<ul style="list-style-type: none"> <li>• General Update</li> <li>• Primary Care Contracts and Performance Report</li> <li>• Finance Report</li> <li>• CQC Report</li> <li>• Annual Plan of Work</li> <li>• Healthwatch GP Report</li> </ul>	
<b>27 October 2020 (in common)</b>	November	<b>22 December 2020</b>
		<ul style="list-style-type: none"> <li>• General Update</li> <li>• Primary Care Contracts and Performance Report</li> <li>• Finance Report</li> <li>• CQC Report</li> <li>• Annual Plan of Work</li> </ul>